STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/31/17 through 11/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 90 certified bed facility was 60 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #13 and #17) and 3 closed record reviews (Residents #14 through #16).	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #5 was reviewed in Restraint Committee meeting on November 13, 2017. The Restraint Committee assessed for a trial reduction, recommendation from the committee was documented. The Restraint Committee recommended a trial reduction with self-releasing seatbelt with a wheel chair pad alarm. Resident #5 will be placed on trial reduction with self-releasing seatbelt with a wheel chair pad alarm in place for a week in an attempt to eliminate seatbelt restraint or reduce to the least restrictive restraint for the least amount of time. The Restraint Committee will reassess after the trial reduction, document the recommendation from the committee and put in place the least restrictive restraint or eliminate the restraint. The Restraint	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	11-21-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review the facility staff failed to ensure 1 resident (Resident #5) of 17 residents in the survey sample was free from a physical restraint. Resident #5 was observed wearing a seatbelt that buckled in the back of the chair. The staff was using the seat belt for fall prevention. The findings included: Resident #5, a 67 year old, was admitted to the facility on 7/23/14. Her diagnoses included schizoaffective disorder, dementia, diabetes, seizures, hypertension, chronic kidney disease and constipation. Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9/29/17. She was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment. She required limited assistance of one person physical assist for bed mobility, transfers, and ambulation. She was coded to be occasionally incontinent of bowel and	F 221	committee will continually try to find least restrictive alternatives or eliminate restraint to ensure residents free of restraint. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with seatbelt or restraint have the potential to be affected by this deficiency. A 100% audit of the residents with restraint will be reviewed to ensure that trail reduction has been done in attempt to eliminate, or reduce to the least restrictive restraint. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Restraint committee will continually try to find, use less restrictive alternatives and eliminate restraints to ensure residents free restraints. The Restraint committee will recommend trial reductions for all residents with restraints and after trial, adjust care to reduce the potential for negative outcomes. 100% In-service of nursing staff will be completed on "Restraint Reduction and Prevention Program" policy. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Quality Assurance nurse will audit 10% of residents' charts with restraints monthly for trial reduction, use less restrictive alternatives or elimination of restraint. Monthly reports will be submitted and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2	F 221		

bladder. Her height and weight were coded as 60 inches and 162 pounds.

The following note was documented in the clinical record on 4/7/17 at 9:10 a.m. "resident also stated that she wanted her seat belt off so she could go to the bathroom by herself. She was reminded by the undersigned and (DON), who was also present, that she needed the seat belt for her safety since she had fallen in the bathroom before due to standing on her own without asking for staff assistance."

The DON was asked to provide the date of Resident #5's last fall. The DON stated the last documented fall was 12/6/15.

On 11/1/17 at 3:15 p.m., Resident #5 was observed in her room sitting in her wheel chair. Registered Nurse D (RN D) was present for the observation. Resident #5 was asked if she could take off her seat belt. She stated no because it buckled in the back. Resident #5's feet were observed to touch the ground. While Resident #5 did not appear to be sliding down in the chair, RN D stated that Resident #5 slides down in her chair.

The form "Consent For Use Of Restrictive Device(s)" was signed by the responsible party on 8/25/16. The form documented that Resident #5 was prescribed the following restrictive devices:
1. Half Rails- Used to assist in turning and positioning the patient
2. Seat belt- Used for safety/ poor judgement

The form "Medical/ Protective Restraint" dated May 2017 was located in the clinical record. The seat belt was listed on the form. The reason for

discussed during Quality Assurance committee meeting.

5. Include dates when the corrective action will be completed.

December 28, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3	F 221		

restraint read, "Poor judgement, safety."
The section "Periods when Devices Are Not Applied" read "Not applicable."

Resident #5 wears the seat belt whenever she sits in the wheelchair.

The most current physician order dated 10/26/17 read "safety belt in chair".

The following assessments of the seat belt were included in the clinical record:
- 8/1/16: "Protective/ Medical Device Monitoring Form" read "seat belt- poor judgement restraint committee recommended to continue with plan due to poor judgement".
- 1/11/17: "Interdisciplinary Team Care Management Conference" read "lap belt for positioning when up in chair."
- 7/24/17: "Protective/ Medical Device Monitoring Form" read "no reduction recommended at this time due to poor judgement. she seen in maintenance for ambulation 3 x wk for up to 250+ feet." (sic)
- 9/18/17: "Protective/ Medical Device Monitoring Form." The form read "seat belt- poor judgement committee recommended to continue with POC (plan of care) due to poor judgement because dementia/ schizoaffective bipolar type and cognitive disorder."

On 11/2/17 at 1:20 p.m., the facility staff were asked to provide the medical diagnosis or symptom that warranted the use of the restraint. The Director of Nursing (DON) and the consulting psychiatrist referenced the Psychiatric Progress note/ Quarterly Review dated 9/28/17. They referred to the diagnoses documented in the note "Impression: Schizoaffective Disorder (SAD),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4	F 221		

Bipolar type; cognitive disorder NOS/ dementia NOS." The psychiatrist and DON stated that Resident #5 needed the restraint because she has poor judgement and can't self regulate due to her cognitive impairment and mental illness. The DON stated that she did not want Resident #5 to fall on her watch.

The facility staff provided two nursing notes that they felt documented Resident #5's poor judgement:

6/14/17 nursing note "Patient became very combative when she could not get a cola. She quickly undid her maintenance sensor, returning to her wheelchair while being verbal abusive. An staff tried to secure her in the wheelchair, she started bucking and thrashing around the wheelchair."

8/5/17 nursing note "Pt (patient) removed half rail, + got out of bed. Found standing @ dresser stated she was getting clothes. Pt (patient) placed in w/c.

The Administrator stated that during the observation conducted with RN D on 11/1/17, Resident #5 was noted to slide down in the chair. When asked if the facility had tried to use a wedge cushion for positioning, facility staff stated no. The DON stated that they had tried a chair alarm and Resident #5 unclipped from her shirt. When asked if they had tried a pad alarm, the DON stated that the facility did not use pad alarms. When asked if the facility had conducted a trial reduction of the seat belt use, the facility staff stated no.

Earlier in the morning on 11/2/17, the facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5	F 221		

had offered the example that Resident #5 did not have the seat belt on, she would stand up to try and dance. They also offered the example that Resident #5 would try to go to the bathroom alone if she didn't have the seat belt on. When asked if the resident was on a toileting program, the DON stated yes. Information about the toileting program was requested.

On 11/2/17 at 12:30 p.m., the DON and Certified Nursing Assistant H (CNA H) discussed the toileting plan. The DON stated that there was no toileting plan because the resident could tell staff when she needed to use the bathroom. CNA H stated that when Resident #5 asked to use the bathroom she (CNA H) needed to release the seat belt for the resident and help her pull down the brief and pants. CNA H stated that Resident #5 did the rest of the toileting task on her own. CNA H stated that she would check in on Resident #5, help her get her pants pulled up and then lock her back in the chair. CNA H stated that once staff knew the resident was safe (buckled in wheel chair), they let her go. CNA H was asked if she thought it would help Resident #5 to be on a toileting program where staff asked her periodically if she needed to use the bathroom, CNA H stated she thought that could work. When asked if she thought the seat belt was in place for staff convenience, CNA H stated that it was easier to have it on her because it is safer.

CNA H explained that Resident #5's room was purposely at the end of the hall near where the CNAs were supposed to be located. She stated that there was a stairwell door at the end of the hall that Resident #5 may try and exit if she didn't have the seat belt on. CNA H stated that in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 6	F 221		

mornings she checks with Resident #5 first to see if she wants to get up. CNA H stated that after Resident #5 is up and safe (buckled in wheelchair) the staff can go give care to other residents.

On 11/2/17 at 10:00 a.m. the physical therapist (PT) discussed Resident #5's therapy. She stated that Resident #5 currently walks with an assistive device with supervision. She stated that originally the seat belt buckled in the front, but Resident #5 would unbuckle the belt. The PT stated that the placement of the belt buckle was changed to the back of the chair for Resident #5's safety because she has the potential for falls and needs redirection. The PT stated that the purpose of the belt was to try and maintain safety.

Restorative nursing currently worked with Resident #5. Documentation for October 2017 was provided. The goal of therapy read "Amb (ambulate) with patient using a RW (rolling walker) with stand-by to contact guard assistance x 1. Pt. (patient) to ambulate up to 200+ feet (3-5x/wk)." Resident #5 completed eight days and refused nine days.

The care plan for "risk for fall/fracture" and "restraint use" dated 7/12/17 was provided by the facility. The care plan problem read "Independent in bed mobility and locomotion on unit in wheelchair" and "She requires assistance with transfers, dressing, toileting, personal hygiene and bathing." One of the interventions read "Seat belt in wheel chair d/t (due to) unsafe and impulsive."

On 11/2/17 at the end of day meeting, the restraint issue was reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 7 Administrator and Director of Nursing.	F 221		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure a safe environment on 2 of 2 units. The Cook/ Chill room that holds the heating and refrigeration unit for meal service was observed unlocked on both units	F 323	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was affected by this deficient practice. Upon notification of the deficiency the second floor Cook/Chill self-locking door adjustment was completed so it closes timely to prevent resident from entering. The third floor Cook/Chill door parts was ordered so it is a self-locking door. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficiency. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Cook/Chill door on second floor has been adjusted to protect both employees and residents. The Cook/Chill on third floor will have a self- lock to ensure a safe environment. A 100% education of all staff on keeping the Cook/Chill door locked at all times will be done. The Nursing staff will check every shift the Cook/Chill doors to ensure a safe environment on each unit by documenting on the monitoring sheet that both doors are locked and report any issues.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 The findings included: On 11/1/17 at 9:15 a.m., the Cook/Chill room was unlocked on the 3rd floor. A male resident in a wheel chair was observed rolling in the hallway nearby. Stored in the room was the heating and refrigeration unit with the food cart attached. In addition, hand sanitizer, sanitation wipes, plates and adaptive eating equipment were stored in the room. The Occupational Therapy (OT) Director entered the room. When asked if the door to the room was supposed to be locked, she stated yes. On 11/1/17 at 11:05 a.m., the door to the Cook/Chill room was half way open on the 2nd floor. The food cart had been removed from the heating/ cooling unit. The heating unit was hot to the touch. The temperature gauge on the unit read "idle". There were no staff or residents in the area. A staff member returned to the the cook/ chill room for supplies. When asked if the door was supposed to be open, she stated no. The issue was reviewed with the Administrator and Director Nursing (DON) at the end of day meeting on 11/1/17. The Administrator stated that on the 2nd floor, staff had been injured by the door because it closed to hard and fast. The door was fixed to close more slowly.	F 323	4. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The facility will audit every shift the Cook/Chill doors to ensure a safe environment on each unit. Monthly maintenance checks will be completed to ensure doors are closing properly and reported to the Quality Assurance Committee. 5. Include dates when the corrective action will be completed. December 28, 2017	